U.S. Department of State
Office of Medical Services, M/MED, Washington, DC 20520-0102

MEDICAL CLEARANCE UPDATE

OMB APPROVAL NO. 1405-0131
EXPIRATION DATE 04/30/2017
ESTIMATED BURDEN: 30 MINUTES*

PRIVACY ACT NOTICE This information is requested pursuant to the Foreign Service Act of 1980, as amended (Title 22 U.S.C. 4084). The primary purpose for soliciting this information is to make appropriate medical clearance decisions. Unless otherwise protected by medical privacy regulations, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and administration purpose. It may also be disclosed pursuant to court order. More information on the routine uses for the system can be found in the System of Records Notice State-24, Medical Records. Providing this information is voluntary; however, failure to provide this information may result in denial of a medical clearance.

TO BE FILLED OUT BY EXAMINEE *(Complete all sections on both sides, type or in ink.)* | Date *(mm-dd-yyyy)*

1. Name of Examinee *(Last, First, MI)*

2. If Family Member, Name of Employee *(Applicant)*

3. MED ID Number *(If available)*

4. Date of Birth *(mm-dd-yyyy)*

5. Sex
☐ Male
☐ Female

6. Place of Birth
City _____ State _____ Country _____

7. Status
☐ Employee/ Applicant ☐ Spouse ☐ Daughter
☐ Son ☐ Domestic Partner

8. Name of Your Health Insurance Plan

9a. Agency
☐ State ☐ USAID ☐ Other _____

10. Your Mailing Address *(Medical Clearance Abstract and all clearance correspondence will be mailed to listed address.)*

9b. Type of Employment
☐ Foreign Service ☐ Contractor ☐ Civil Service Excursion Tour

11. Post of Assignment/Date of Departure/Arrival *(mm-dd-yyyy)*
a. Proposed Post _____ EDA _____
b. Present Post _____ EDD _____
c. Last 3 Posts _____

Telephone Numbers *(Where You Can be Reached for the Next 90 Days)*

E-mail Address *(Where You can be Reached for the Next 90 days)*

Health Unit Comments *(Attach Additional Sheets if Needed)*

Signature of Provider | Date *(mm-dd-yyyy)*

☐ Recommend Class 1 Clearance - Unlimited

☐ Recommend Class 2 Clearance - Specific

☐ Recommend Full Physical Examination For Clearance Decision

Additional Comments

Print Name

Signature of RMO/FSHP or Locally Engaged Physician or Nurse | Date *(mm-dd-yyyy)*

*Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: Department of State, Office of Medical Clearances, SA-15, Room 400 1800 North Kent Street, Rosslyn, VA 22091.

Instructions: Please answer each of the following questions with particular emphasis on the period of time since your last medical clearance was issued. Be sure to attach copies of any medical reports that will be helpful in clarifying the medical situation. Failure to provide us with pertinent information will delay processing of the clearance decision and post approval for an onward assignment. Discuss this form with your Health Unit medical personnel or Foreign Service Medical Provider. You or your Health Unit should scan and email this form to MEDMR@state.gov. If it is not possible to scan, please fax the form to Medical Records at Fax: 703-875-4850.

Since your last Medical Clearance was issued:

1. Have you seen a health care provider for routine health maintenance? Examples: Blood pressure, PPD, lipid profile, Pap smear, mammogram, screening for colon cancer. If so, provide results of tests.	☐ Yes	☐ No
2. Have you been hospitalized or medevaced? If yes, explain:	☐ Yes	☐ No
3. Have you had any change in your medications since your last medical clearance? If yes, explain:	☐ Yes	☐ No
4. Have you been treated for any ongoing medical or mental health condition? If yes, explain:	☐ Yes	☐ No
5. Do you have any physical or emotional concerns that you feel should be evaluated?	☐ Yes	☐ No
6. Do you have a Class 2 clearance? If yes, please provide update from your medical provider to include diagnosis, current treatment and follow-up schedule.	☐ Yes	☐ No

For Children

7. Does the child have any special educational needs or requirements such as tutoring or other special assistance? If yes, please have a School Report of Progress completed by the child's teacher and/or tutor and attach it to this form.	☐ Yes	☐ No
8. Do you anticipate any special educational needs or requirements at anytime in the future?	☐ Yes	☐ No

For Pregnant Women

If you are pregnant and you are assigned to La Paz or are considering assignment to La Paz please be aware that the current recommendation for pregnant women is for them to leave La Paz as soon as possible after confirmation of pregnancy. The extreme altitude, over 10,000 feet above sea level, in La Paz can have a negative effect on the fetus.

Please answer the following questions if you have been assigned to a high threat/unaccompanied post in the last three years:

9. Have you been injured or experienced a blast or explosion? If yes, explain:	☐ Yes	☐ No
10. Have you been exposed to any known toxic chemicals? If yes, explain:	☐ Yes	☐ No

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month you:

11. Have had nightmares about it or thought about it when you did not want to?	☐ Yes	☐ No
12. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	☐ Yes	☐ No
13. Were constantly on guard, watchful, or easily startled?	☐ Yes	☐ No
14. Felt numb or detached from others, activities, or your surroundings?	☐ Yes	☐ No

I understand the Medical Clearance Update is not a substitute for routine health care. Please send in a DS-3057 or a DS-1843/1622 but not both.

_____ _____

Signature of Examinee/Parent/Guardian Date *(mm-dd-yyyy)*

The intentional omission of any crucial medical information is a criminal offense (Section 1001 of the U.S.C. Title 18). For this offense employees may also be subject to disciplinary action.